

2216-001 \$ 25.00  
2216-001 \$ 25.00  
2216-006 \$ 10.00



**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TN 37243  
(615) 532-5088, or (800) 778-4123 ext. 25088  
[www.state.tn.us/health](http://www.state.tn.us/health)**

**APPLICATION FOR CERTIFICATION AS AN X-RAY OPERATOR IN A PODIATRIST'S OFFICE**

**INSTRUCTIONS**

1. Complete this application, have it notarized and mail it to the above address.
2. Enclose a non-refundable check for \$ 60.00, payable to the Board of Podiatric Medical Examiners.
3. Attach a recent photograph to the front of this application.
4. Enclose proof of being at least eighteen (18) years of age.
5. Enclose proof of graduation from high school or its equivalent.
6. Enclose, or have submitted official verification of successful completion of (60) hours of supervised clinical experience in radiographic methodology, technique, patient care and positioning, equipment maintenance, radiation protection and x-ray quality control.
7. Enclose, or have submitted an official verification of attendance and successful completion of six (6) contact hours of didactic classroom instruction in the field of x-ray operation. (See rules for sponsoring provider.
8. If you are certified in another state(s) as an x-ray operator and or any other health professional, do not complete page 4, instead enclose a copy of the statutes and rules governing your practice in that state. Submit a current verification of active licensure/certification from the other state your residing in.
9. Examination Requirement – In order to be certified pursuant to this Chapter, the applicant must successfully complete an examination approved by the Board and must correctly answer at least seventy percent (70%) of the questions on that exam. (Please see rule 1155-03-.02 for approved examination providers.
10. Criminal Background check required as of July 17, 2006 [click here](#) for instructions

Name \_\_\_\_\_  
(First) (Middle and/or Maiden) (Last)

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Month) (Day) (Year)

Current Mailing Address

Current Practice Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

List all states where you currently have, or have ever had a health professional license or certification.

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnoses (if necessary) and exercise reasoned judgments and to learn and keep abreast of professional developments; and
  - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

### QUESTIONS:

- |  | YES   | NO    |
|--|-------|-------|
| 1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?   | _____ | _____ |
| a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?   | _____ | _____ |
| b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? | _____ | _____ |

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]*

### QUESTIONS

- |  | YES   | NO    |
|--|-------|-------|
| 2. Do you currently use chemical substances?   | _____ | _____ |
| If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?  |       |       |
| Please list the substances used _____  |       |       |
| 3. Are you currently engaged in the illegal use of controlled substances?  | _____ | _____ |
| If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?   | _____ | _____ |
| 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?  | _____ | _____ |
| 5. If you have held or applied for a license or certificate to practice as an x-ray operator in any state, country or province, has or was it ever been denied, reprimand, suspended, restricted, revoked, or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**



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**Podiatrist's Statement of Clinical Experience**

This form must be completed and signed by the supervising podiatrist. This form must be mailed separately from the application and sent to the above address.

Name of Applicant: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby certify that the above named x-ray operator has obtained sixty (60) hours of clinical training as required in Rule 1155-3-.02(2)(a). Please indicate the number of supervised hours in each of the qualifications that apply.

_____	training in radiographic methodology
_____	technique
_____	patient care and positioning
_____	equipment maintenance
_____	radiation protection
_____	x-ray quality control
_____	other (please describe) _____

Please make a brief statement regarding the professional competence of this applicant: \_\_\_\_\_

\_\_\_\_\_  
Podiatrist's Name (Please Print)

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Podiatrist's Signature

\_\_\_\_\_  
Date



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**CLEARANCE FROM OTHER STATE LICENSURE/CERTIFICATION**

Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have ever held a license to practice as an health professional. (If additional forms are required this form may be duplicated.) **NOTE:** Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state(s).

\*\*\*\*\*  
I was granted \_\_\_\_\_ on \_\_\_\_\_ by the State of \_\_\_\_\_  
License# \_\_\_\_\_ Date \_\_\_\_\_

The Tennessee Board of Podiatric Medical Examiners requests that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Podiatric Medical Examiners.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Printed Name: \_\_\_\_\_

\*\*\*\*\*

**THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD**

License Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Basis of Issuance: Endorsement/Reciprocity With: \_\_\_\_\_  
Written Examination: \_\_\_\_\_

Is the License currently registered: \_\_\_\_\_ Yes \_\_\_\_\_ No (Provide Description of Exam)

Derogatory Information on File: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes" please attach explanation.

\_\_\_\_\_  
Authorized Signature Title Date

JK/G6019344/POD